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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

4. SHRHAPDSH Payments (cont.)

Hospitals qualifying for SRHAPDSH payments started earning payments under this plan July 1, 1994, from a legislatively appropriated pool. The apportionment formula is based on each SRHAPDSH hospital's Medicaid and other low-income reimbursement during the most current state fiscal year less any low-income disproportionate share payments.

To determine each hospital's percentage of Medicaid payments, the sum of individual hospital payments is divided by the total Medicaid payments made to all SRHAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of payments, hospitals with a low profitability margin will have their total payments set at 110% of actual payments. MAA will calculate each hospital's net operating margin based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines.

Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them. Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRHAPDSH pool. The payments are made periodically. SRHAPDSH payments are subject to federal regulation and payment limits.

5. Small Rural Hospital Indigent Adult Assistance Program Disproportionate Share Hospital (SRHIAAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a SRHIAAPDSH payment if:

a. The hospital is an in-state (Washington) hospital; and

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

5. SHRHIAAPDSH Payments (cont.)

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard increased by two percent each subsequent SFY; and

d. The hospital qualifies under Section 1923(d) of the Social Security Act; and

e. The hospital provided services to low-income, Medically Indigent (MI) patients during the calculation base year. MI persons are low-income individuals who are not eligible for any health care coverage and who are encountering emergency medical conditions.

Hospitals qualifying for SRHIAAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. The apportionment formula is based on each SRHIAAPDSH hospital's calculated costs for qualifying MI patients during the most currently available state fiscal year.

To determine each hospital's percentage of MI payments, the sum of individual hospital calculated MI costs is divided by the total MI calculated costs of all SRHIAAPDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of calculated MI costs, hospitals with a low profitability margin will have their total calculated MI costs adjusted to 110% of calculated MI costs. MAA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Payments for SRHIAAPDSH will be made in conjunction with payments for SRHAPDSH.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

5. SHRHIAAPDSH Payments (cont.)

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRHIAAPDSH pool. The payments are made periodically. SRHIAAPDSH payments are subject to federal regulation and payment limits.

6. Teaching Hospital Assistance Program Disproportionate Share Hospital (THAPDSH) Payment (Program ends June 30, 2005)

Effective July 1, 1994, teaching hospitals shall be deemed eligible for a THAPDSH payment if they meet the following eligibility standards:

a. The hospital must be a Washington State university hospital; and

b. The hospital must have at least two obstetricians, with staff privileges at the hospital, who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services. This standard does not apply to hospitals which do not offer non-emergency obstetric services to the general population; and

c. The hospital must have a Medicaid low-income utilization of 20 percent or above.

Hospitals qualifying for THAPDSH payments started receiving payments under this plan July 1, 1994. THAPDSH payments will be made from a legislatively appropriated pool and are equally divided between THAPDSH qualified hospitals.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

7. State Teaching Hospital Financing Program Disproportionate Share Hospital (STHFPDSH) Payment (Program ends June 30, 2005)

Effective June 15, 1997, hospitals shall be deemed eligible for a STHFPDSH payment if:

a. The hospital provides at least 20 percent of its services to low-income patients; and,

b. The hospital is a Washington state-owned university hospital (border area hospitals are excluded); and,

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

d. The hospital qualifies under section 1923(d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payment to state and county teaching hospitals.

The STHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

8. County Teaching Hospital Financing Program Disproportionate Share Hospital (CTHFPDSH) Payment (Program ends June 30, 2005)

Effective July 1, 1993, hospitals shall be deemed eligible for a CTHFPDSH payment if:

a. The hospital provides at least 25 percent of its services to low-income patients;

b. The hospital is a county hospital in Washington State (border area hospitals are excluded);

c. The hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and,

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont)

8. CTHFPDSH Payments (cont.)

d. The hospital qualifies under section 1923 (d) of the Social Security Act.

The hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount of the legislatively appropriated pool only for disproportionate share payments to state and county teaching hospitals.

The CTHFPDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

9. Public Hospital District Disproportionate Share Hospital (PHDDSH) Payment (Program ends June 30, 2005)

Effective June 1, 1995, hospitals shall be deemed eligible for a PHDDSH payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a Public District Hospital in Washington State (as of June 15, 1997, border area public hospitals are included);

c. The hospital qualifies under section 1923 (d) of the Social Security Act.

d. The hospital is not department approved and DOH certified as CAH under Washington State Law and federal Medicare rules.

Public hospital districts are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

9. PHDDSH Payments (cont.)

Hospitals that apply and are deemed eligible under the above criteria shall receive a disproportionate share payment for hospital services during the State's fiscal year that in total will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines. Each hospital will receive a payment based on the factors specified in Section 1923(g) of the Social Security Act. Payments in the program shall be based on the relative amount of uncompensated care incurred by the hospital during the year preceding payment. Hospitals deemed eligible under the above criteria shall receive a periodic disproportionate share payment amount. The pool for PHDDSH payments is legislatively appropriated.

The PHDDSH payments may vary and are contingent upon the federal allotment for state disproportionate share cap.

10. Non-Rural Hospital Indigent Adult Assistance Program Disproportionate Share Hospital (NRHIAAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a NRHIAAPDSH payment if:

a. The hospital provides at least one percent of its services to low-income patients in Washington state; and

b. The hospital does not qualify as a Small Rural Hospital as defined in section G.4.a and G.4.c. of this plan; and

c. The hospital qualifies under Section 1923(d) of the Social Security Act.

Hospitals qualifying for NRHIAAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. The apportionment formula is based on each NRHIAAPDSH hospital's calculated costs for patients in the Medically Indigent program during the most currently available state fiscal year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

G. DSH PAYMENTS (cont.)

10. NRHIAAPDSH Payments (cont.)

To determine each hospital's percentage of payments for patients in the Medically Indigent program, the sum of individual hospital calculated costs is divided by the total calculated costs for patients in the Medically Indigent program of all NRHIAAPDSH hospitals. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2003, prior to calculation of the individual hospital's percentage of costs for patients in the Medically Indigent program, hospitals with a low profitability margin will have their total calculated MI costs adjusted to 110% of calculated MI costs. MAA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the NRHIAAPDSH pool. The payments are made periodically. NRHIAAPDSH payments are subject to federal regulation and payment limits.

11. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals shall be deemed eligible for a PHDSH payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a public hospital in Washington State (includes the Harborview Medical Center, the University of Washington Medical Center, and public hospitals located in the State of Washington that are owned by public hospital districts;

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G. DSH PAYMENTS (cont.)

11. PHDSH Payments (cont.)

c. The hospital qualifies under section 1923 (d) of the Social Security Act.

d. The hospital is not department-approved and DOH certified as CAH under Washington State Law and federal Medicare rules.

Harborview is a county-owned, state-operated hospital. The University of Washington Medical Center is a state-owned and operated hospital. Public hospital districts located in the State of Washington are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Those public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Hospitals that apply and are deemed eligible under the above criteria shall receive a disproportionate share payment for hospital services during the State's fiscal year that in total will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines. Payments in the program shall be based on the amount of uncompensated care incurred by the hospital during the year preceding payment.

The DSH payment will be based on expenditures certified by the hospital in an amount as specified in the preceding paragraph.

G. CUSTOMARY CHARGE PAYMENT LIMITS

As required by 42 CFR 447.271, total annual Medicaid payments to each hospital for inpatient hospital services to Medicaid recipients shall not exceed the hospital's customary charges to the general public. The state may recoup amounts of total Medicaid payments in excess of such charges. This customary charge limit does not apply to CAH cost settlement.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

H. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedure

A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the DSHS (the Medical Assistance Administration) except that no administrative appeals may be filed challenging the method described herein.

The grounds for rate adjustments include, but are not limited to, errors or omissions in the data used to establish rates, changes in capital costs due to licensing or certification requirements, and peer group change recommended by the Medical Assistance Administration.

Additional documentation, as specified by DSHS, may be required in order to complete the appeal review. DSHS (the Medical Assistance Administration) may have an audit and/or desk review conducted if necessary to complete the appeal review. A hospital may appeal its rates by submitting a written notice of appeal to the Office of Hospital and Managed Care Rates, Medical Assistance Administration.

Unless the written rate notification specifies otherwise, a hospital rate appeal requesting retroactive rate adjustments must be filed within 60 days after being notified of an action or determination the hospital wishes to challenge. The notification date of an action or determination is the date of the written rate notification letter.

A hospital rate adjustment appeal, filed after the 60-day period described in this subsection shall not be considered for retroactive adjustments.

When an appeal is made, all aspects of this rate may be reviewed by DSHS.

Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal filed within 60 days after the written rate notification letter that the hospital is challenging shall be effective retroactively to the effective date of the rate change as specified in the notification letter.

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H. ADMINISTRATIVE POLICIES (cont.)

Increases in rates resulting from a rate appeal filed after the 60-day period or exception period shall be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases shall be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the MAA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete their official annual Medicare cost report (CMS 2552) according to the applicable Medicare statutes, regulations, and instructions and submit a copy of their official annual Medicare cost report (CMS 2552), including Medicaid related data, to MAA. This submittal to MAA should be an identical copy of the official Medicare cost report (CMS 2552) submission made by the hospital provider to the Medicare fiscal intermediary for the hospital's fiscal year.

The Medicare cost report (CMS 2552) should be submitted to MAA within one hundred fifty days from the end of the hospital's fiscal year, or if the hospital provider's contract with DSHS is terminated, within one hundred and fifty calendar days of the effective termination date.

The hospital may request up to a thirty-day extension of the deadline for submitting the Medicare cost report (CMS 2552) to MAA. The extension request must be in writing and be received by MAA at least ten calendar days prior to MAA's established due date for receiving the report. The extension request must clearly explain the circumstances leading to the reporting delay. MAA may grant the extension request if MAA determines the circumstances leading to the reporting delay are valid.

In cases where Medicare has granted a hospital provider a delay in submitting its Medicare cost report (CMS 2552) to the Medicare fiscal intermediary, MAA may grant an equivalent reporting delay.

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H. ADMINISTRATIVE POLICIES (cont.)

This reporting delay may be granted when the hospital provider provides MAA a copy of the written notice from Medicare that granted the delay in Medicare cost report (CMS 2552) reporting to the Medicare fiscal intermediary. The hospital provider should submit a written extension request to MAA, along with the copy of the written notice from Medicare, at least ten calendar days prior to MAA's established due date for receiving the Medicare cost report (CMS 2552).

If a hospital provider submits to MAA a copy of an improperly completed Medicare cost report (CMS 2552) or a copy that is not the official Medicare cost report (CMS 2552) that has already been submitted for the fiscal year to the Medicare fiscal intermediary, or if the cost report is received after MAA's established due date or approved extension date, MAA may withhold all or part of the payments due the hospital until MAA receives a copy of a properly completed Medicare cost report (CMS 2552) that has been submitted for that fiscal year to the Medicare fiscal intermediary.

In addition, hospitals are required to submit other financial information as requested by MAA to establish rates.

3. Financial Audit Requirements

Cost report data used for rate setting will be periodically audited.

In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS will rebase the Medicaid payment system on a periodic basis using each hospital's Medicare cost report (CMS 2552) for its fiscal year ending during the base year selected for the rebasing.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

I. UPPER PAYMENT LIMIT PAYMENTS FOR PUBLIC HOSPITALS OWNED BY PUBLIC HOSPITAL DISTRICTS, AND STATE AND COUNTY TEACHING HOSPITALS, THAT ARE LOCATED IN THE STATE OF WASHINGTON

1. An upper payment limit (UPL) pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid patient services. Eligible providers are King County-owned or Washington State-operated teaching hospitals, and public hospitals owned by public hospital districts, located in the State of Washington that are not department approved and DOH certified as CAH, as designated each year by the department.

2. The supplemental payments made to eligible providers are subject to prior federal approval for obtaining federal matching funds for the supplemental payments. The supplemental funds are subject to the federal Medicare upper payment limit for hospital payments. The Medicare upper limit analysis will be performed prior to making the supplemental payments.

3. The Medicare Upper Payment Limit (UPL) payment for each payment year is determined as follows:

   The cumulative difference between the UPL and Title XIX payments and third party liability payments for all eligible hospitals during the most recent Federal Fiscal year becomes the total UPL payment that will be distributed during the payment year. The source of the charge and payment data is the State's Medicaid Management Information System (MMIS) for the base year. Only charges and payments for inpatient hospital services are included in the computation, and the base year determined amount is not inflated to the payment year.

4. Payments will be distributed to the eligible hospitals based on eligibility under the UPL, in proportion to the dollars resulting from the difference between Hospital Allowed Charges and Title XIX payments, including third party. The supplemental payment is at least annually during each federal fiscal year.